GEORGIA DEPARTMENT OF HUMAN RESOURCES
Division of Mental Health, Developmental Disabilities and Addictive Diseases
Behavioral Health Provider Application for Accredited Providers

Note: Currently the Division is accepting applications for all Child and Adolescent providers who are interested in providing services to this target population through a fee for service provider agreement.

Organizations will find it useful to review the Division's Provider Manual that is available at http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/, click on Provider Information and then the link for the Provider Manual. Included in the Provider Manual are the service definitions, provider standards and applicable policies and procedures.

SECTION I - APPLICATION TYPE

APPLICATION IS BEING SUBMITTED FOR:

Qualified Provider: (check appropriate box) Applicants must also submit simultaneously, the Medicaid Rehabilitation Option (MRO) application materials that are found at https://www.ghp.georgia.gov in order to be enrolled as MRO providers once approved as a Qualified Provider.

☐1. Current MHDDAD Provider Applying for Qualified Provider Status
☐2. New Provider of MHDDAD Services Applying for Qualified Provider Status and MRO
☐3. Qualified/MRO Provider Applying for New Service at a Currently Established Site
☐4. Qualified/MRO Provider Applying for New Service at a New Site including MRO
☐5. Qualified/MRO Provider Applying for an Address Change for a Currently Established Site

Services: The organization will provide (check appropriate boxes)

Child and Adolescent Services
☐**Core Services**

☐**Specialty Services**
- ☐Intensive Family Intervention
- ☐Crisis Residential Services
- ☐ Community Inpatient

Accreditation: Indicate the status, type of accreditation and dates of accreditation.

Accreditation Body	Status	Accreditation Expiration Date	Accreditation Type
JCAHO	Applied ☐Yes ☐No Accredited ☐Yes ☐No	___/___/_____	☐Intensive Outpatient ☐Outpatient ☐In-patient
CARF	Applied ☐Yes ☐No Accredited ☐Yes ☐No	___/___/_____	☐Intensive Outpatient ☐Outpatient ☐In-patient
COA	Applied ☐Yes ☐No Accredited ☐Yes ☐No	___/___/_____	☐Intensive Outpatient ☐Outpatient ☐In-patient
CQL	Applied ☐Yes ☐No Accredited ☐Yes ☐No	___/___/_____	☐Intensive Outpatient ☐Outpatient ☐In-patient

SECTION II - CORPORATE ENTITY/MAIN GEORGIA SITE

A. CORPORATE HEADQUARTERS

Location Name: _____ FEI Number: _____

Street Address:

Mailing Address (if different):

CEO/Director:

Contact Name:

Telephone: Fax:

Email Address: Website:

B. MAIN GEORGIA SITE

Legal Name: _____ FEI Number: _____

Street Address:

Mailing Address (if different):

CEO/Director:

Contact Name:

Telephone: Fax:

Email Address: Website:

d/b/a or other alternate business name (if any)

SECTION III – SERVICE LOCATION

Please submit Section III by location (core or specialty, specify the specialty service) where services are to be offered. Agencies may submit multiple copies of Section III for each service location.

A. SERVICE(s): _____ (specify)

B. SERVICE DELIVERY LOCATION

Location Name:		
Street Address:		
City:	County:	Zip:
Clinical Contact Person		Title:
Telephone:	Fax:	
Email Address:	Website:	

C. BILLING INFORMATION

Billing Name:		
Billing Address:		
City:	State:	Zip:
Billing Contact Person		Title:
Telephone:	Fax:	
Email Address:	Website:	

D. BUSINESS HOURS: For **Core Services**, indicate times in appropriate block.
Core Service providers must operate a minimum of 52 hours per week to allow access to services for individuals who work or are otherwise engaged in activities during traditional 8-5 business hours. This will be accomplished by maintaining business hours after 5:00 PM Monday – Friday and on the weekends. Complete the grid to demonstrate how your agency will meet these requirements.
For **Intensive Family Intervention** providers, it is expected that these services and supports be provided when and where the family needs them and in compliance with the service definition and guidelines.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							
Evening							
By Appt							

Is this location within one block of public transportation? ☐ Yes ☐ No

Is this location wheelchair accessible? ☐ Yes ☐ No

Does this location have Telecommunications Device for the Deaf (TDD)? ☐ Yes ☐ No

E. CORE SERVICE PROVIDERS: AFTER HOUR ACCESSIBILITY FOR CONSUMERS IN TREATMENT AND NEW REFERRALS

☐ Answering Machine ☐ Answering Service ☐ Beeper ☐ Clinicians On Call

INTENSIVE FAMILY INTERVENTION: AFTER HOUR ACCESSIBILITY FOR CONSUMERS IN TREATMENT

☐ Answering Machine ☐ Answering Service ☐ Beeper ☐ Clinicians On Call

F. STAFFING

Complete Staffing Form 2 and 3 for this location.

G. MEDICAID PARTICIPATION

Is this service location currently certified as a Georgia Medicaid Rehabilitation Option Provider? ☐ Yes ☐ No

Is this service location currently covered under a provider agreement with a CMO? ☐ Yes ☐ No

Does this service location have Medicaid certification in another State? ☐ Yes ☐ No

If yes, which one(s): _____

Any questions regarding your application must be submitted via email to the following address and remember to include your assigned tracking number.
MHDDAD-serviceapps@dhr.state.ga.us

SECTION IV - PROFESSIONAL AND GENERAL LIABILITY INFORMATION

Please submit this Section for the organization as a whole.

If you answer 'yes' to any of the questions below, please provide documentation describing the circumstances surrounding the event, settlements, and or resolutions of the issues.

A. Has the organization or program or any of the organization's or program's staff been named in any malpractice legal action within the last five (5) years in which a lawsuit was filed against the agency? ☐ **Yes** ☐ **No**

B. Has the organization or program or any of the organization's or program's staff members' malpractice insurance been canceled, non-renewed, restricted or special rated during the last five (5) years? ☐ **Yes** ☐ **No**

C. Has any government agency investigated, suspended, revoked or taken any other action against the organization or program or any of the organization's or program's staff members license to practice within the last five (5) years? ☐ **Yes** ☐ **No**

D. At any time has any license, specialty board certification or eligibility been revoked, reduced denied, or suspended by the issuing entity or voluntarily given up by the organization or program or members of the organization's or program's staff within the last five years? ☐ **Yes** ☐ **No**

E. Has the organization or program or members of the organization's or program's staff had any legal actions brought against them within the last five (5) years or are there any legal actions currently pending? ☐ **Yes** ☐ **No**

F. Has the organization or program or members of the organization's or program's staff received any sanction letters or related documents from any licensing, certifying or credentialing entity within the last five (5) years? ☐ **Yes** ☐ **No**

G. Has the organization or program or members of the organization's or program's staff been debarred or suspended from receiving payment under the Medicare and/or Medicaid Program within the last five (5) years? ☐ **Yes** ☐ **No**

SECTION V - OTHER REQUIRED INFORMATION

Current copies of the following documents must be submitted with this application:

- Evidence of business recorded with Georgia's Secretary of State Office
- All current state and federal licenses and certificates/certifications
- All accreditations (either JCAHO, CARF, or COA).
- Verification of general and professional liability insurance
- Curriculum Vitae for the Georgia CEO/Director which includes a continuous work history for the past five years
- Current Table of Organization for Georgia operations which shows the number of FTEs currently employed in each position and proposed Table of Organization for the Georgia operations which will include the services covered in this application and which also shows the number of FTEs for each position.
- Attestations signed by authorized agency representative (FORM 1)

FORM 1
ATTESTATIONS

A. Core or Specialty Services

Georgia Department of Human Resources requires that only certain Licensed Clinicians may authorize core or specialty services and that services be provided according to the service guidelines and that the agency will operate in accordance with applicable standards, rules and regulations and policies. Consistent with this requirement, I do hereby certify that the organization that is seeking to become a provider of core or specialty services, and on whose behalf I'm acting, will only allow the appropriate Licensed Clinicians to authorize services and operate in accordance with the provider agreement.

B. Medicaid Rehabilitation Option Services

Consistent with DHR policy, I do hereby certify that the organization that is seeking to become a provider of core or specialty Fee-for-Service funded services is also seeking certification as a Medicaid provider under the Rehabilitation Option, if it is not current certified.

C. E-Commerce Capacity

The Georgia Division of MHDDAD requires all providers to be computer literate. This includes the following minimum components:

- Office computer capacity
- Internet capacity
- Email capacity
- Electronic data transfer capacity

Consistent with this requirement, I do hereby certify that this organization, and on whose behalf I'm acting, does maintain each of these components.

D. Authorized Agent

Under penalty for perjury, I do hereby affirm that I am the authorized agent to complete this application and that the information contained in this application is complete, true, and correct.

E. Accreditation Confirmation

The Georgia Division of MHDDAD requires all providers to be accredited within 18 months of the date of this application. Consistent with this requirement, I do hereby certify that this organization, and on whose behalf I'm acting, has already met or will meet this obligation within this timeframe.

_____ _____, _____

Printed Name of Organization | Printed Name of Authorized Representative | Title

_____ _____

Date | Signature of Authorized Representative

FORM 2
STAFFING ROSTER

List all positions involving direct care staff (excluding Licensed/Certified Clinicians, Mental Health Professional and Substance Abuse Professionals)

Child / Adolescent Services

☐ Core Services

☐ Specialty Services

Specify Specialty Services:

_____

_____

Position Title	Brief Position Description	Full Time Equivalent Positions

FORM 3
LICENSED/CERTIFIED CLINICIANS, MENTAL HEALTH PROFESSIONALS AND SUBSTANCE ABUSE PROFESSIONALS

Child / Adolescent Services

☐ Core Services

☐ Specialty Services

Specify Specialty Services:

_____

_____

Attach a copy of each license or certification

Name	Position Title	License/Certification		Date of MHP/ SAM/SAP Designation
		Number	Period	
Medical				
Nursing				
Clinical/MHP/SAM/SAP				
Certified Peer Specialists				

MHP, SAM and SAP are defined in the Divisions Provider Manual. The Provider Manual is available at http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/, click on Provider Information.